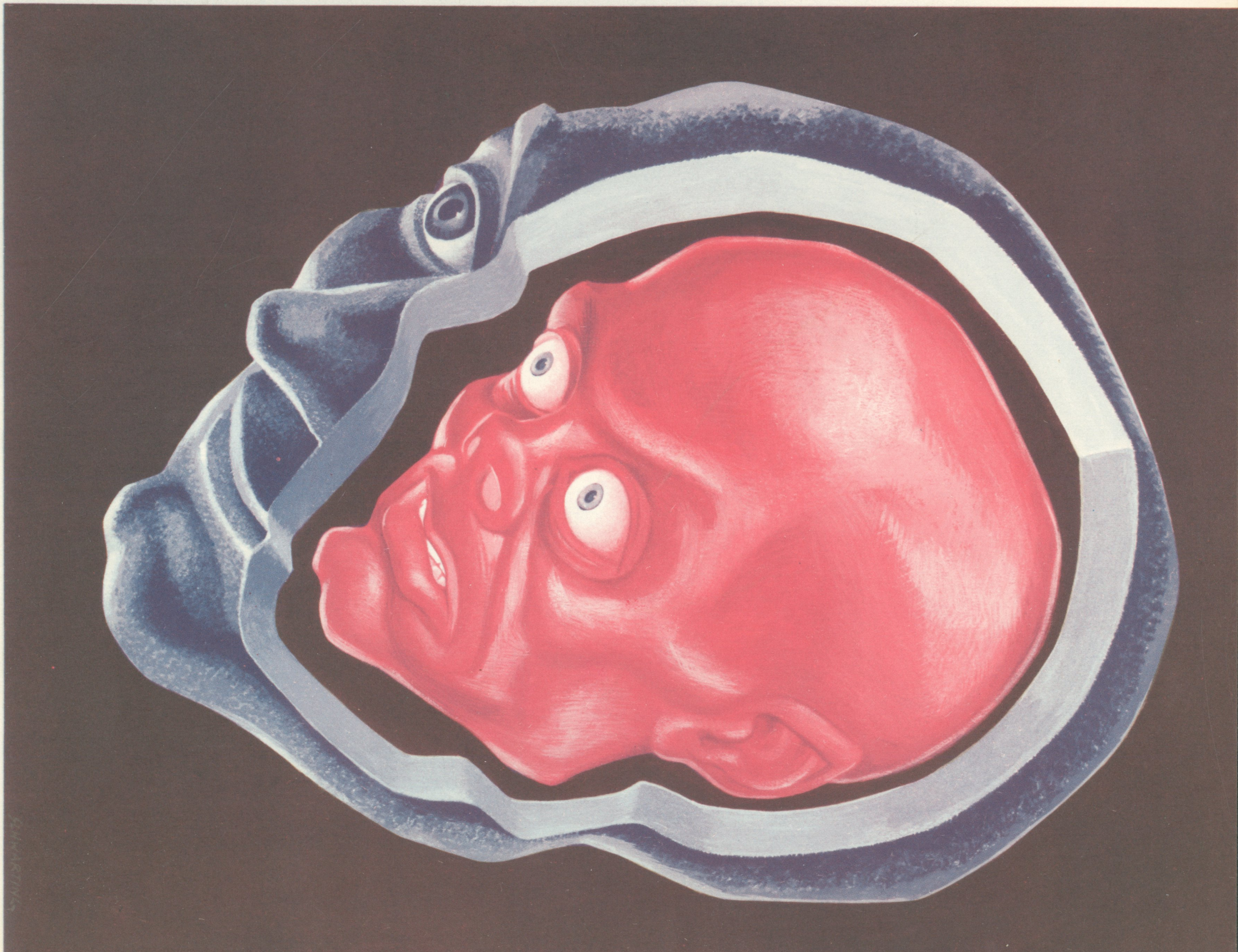
the psychiatric bulletin

FOR THE PHYSICIAN IN GENERAL PRACTICE

WINTER, 1953-1954



AMBULATORY SCHIZOPHRENIA—Page 2

THE
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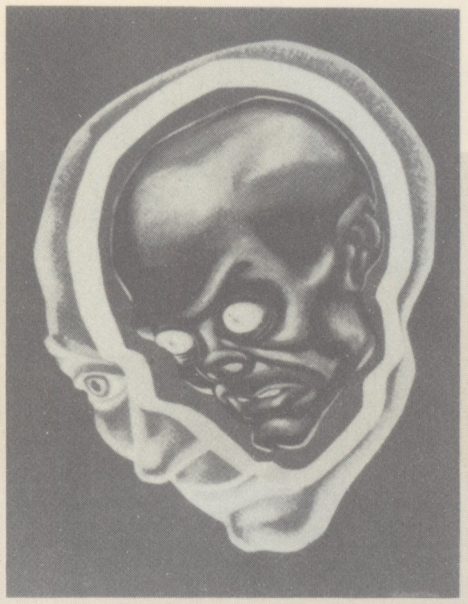

THE COVER

Although he presents an apparently benign exterior, the borderline schizophrenic is dominated by an inner core of hatred, which distorts his impression of the outside world. His contact with reality is tenuous and his exchange with other people, superficial. For a discussion of borderline, or ambulatory schizophrenia, see page 2.

The painting on the cover was executed by Mr. Joseph F. Schwarting.

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THE PSYCHIATRIC BULLETIN

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Volume IV ~ Number 1

Winter, 1953-1954

AMBULATORY SCHIZOPHR

RECOGNITION OF ANY DISEASE in its early stages usually leads to better management. This is no less true of psychiatric disorders than organic ones. It certainly applies to schizophrenia which too often is diagnosed only by the terminal phenomena. Much of the pessimism regarding this disease springs from this failure to recognize the early or primary symptoms.

A group of patients has lately been described whose condition is called ambulatory, borderline or pseudo-neurotic schizophrenia. It is likely that this actually represents an early stage of schizophrenia. Ambulatory schizophrenia is a good descriptive name because, as Zilboorg expresses it, these patients "seem to walk normally through life, casual in their ties, passing as difficult people or problem children." They seem to shift back and forth between neurosis and psychosis, and many are erroneously diagnosed as neurotic, depending on the stage in which they are seen.

They are classified with the schizophrenics because the basic mechanisms are the same. The basic or primary symptoms are: 1. disturbances of thinking, 2. rigidity of affect, 3. ambivalence and 4. withdrawal from reality. The diagnosis depends on the extent to which this constellation of symptoms dominates the personality. It is not necessary that *all* be present.

Subtle, rather than gross, thinking disturbances are present. Thus concreteness in thinking and errors in conceptualization must be looked for rather than incoherence and irrelevance. As the development of thought occurs in children, it passes normally through three stages. The first is "magical." The second is "concrete" thinking, which is literal and realistic. In the second stage, words have a specific and highly personal, rather than a symbolic, meaning. For example, to a child in this phase the word "chair" does not symbolize a whole category of objects on which one sits. To him it means a particular chair in his house, or which belongs to him. After adolesence, the use of language to form abstract concepts develops

ENIA

and forms the basis for grasping general principles and ideas of classification. The schizophrenic has a definite reduction in this highest order of thinking and words have a personal, rather than a symbolic meaning. Zilboorg reports a murderer who said he killed the woman because he had "fallen in love" with her. To him the word "love" meant *only* the primitive sexual impulse. It excluded such abstract qualities as warmth, affection, tenderness, etc. These characterize a broader, more mature, concept of love and preclude such extreme manifestations of hostility.

The emotional behavior of these patients resembles that of the full-blown schizophrenic, though it is less conspicuous. The emotional responses are inappropriate and lack flexibility and modulation. While over-reacting to minor frustrations, they may not respond to major ones. The shy, timid person may burst into furious rage without sufficient reason. Many are cold and emotionally controlled, but hypersensitive to attitudes of others. They are filled with hate, and almost never free of its pressure. Helpless rage, which is diffuse and rarely directed against a particular person or object, accounts for many apparently senseless acts of violence committed by these people. Open hatred for various family members is characteristic. This trait seems to have its source in frustration during infancy which, unless discharged, accumulates progressively, isolating and alienating the patient from his fellow beings. He must find some way of discharging this hatred unless he himself be overwhelmed by it. Many murders and suicides by borderline schizophrenics represent an attempt to discharge this emotion and to defend against a frankly psychotic reaction.

Ambivalence is present to a marked degree in all these patients and it is much more profound and widespread than in the neurotic. Ambivalence means the attachment of strong, but conflicting, emotions upon a person or an object. For example, a man whose father had been on occasion extremely cruel to him and yet at other times very kind, regarded his father with feelings of both hate and love. Conflicting emotions are not limited to only a few people important in the life of these ambulatory schizophrenics. They regard nearly everyone with two sets of emotions. They also have many contradictory impulses which lead to constantly shifting ideas in their approach to reality.

A certain withdrawal from reality is present in these patients, for they do not perceive people and situations as they actually are. Their private world is not necessarily a pleasant place. The turning from reality is subtle and there is little in an objective way to demonstrate it clinically. Much depends upon the individual physician's ability to appraise this significant symptom.

Diagnosis

The diagnosing of the early schizophrenic is not easy. He may appear almost normal, doing his job not too badly although not very well. The intelligence seems to be adequate and it usually has a cultural turn. He thinks more than he talks and this taciturnity may be mistaken for depression. He changes jobs often and goes from one interest to another. He goes through the motions of living, conforming outwardly to the demands of society. He has many acquaintances, but only a few intimate friends, and even these do not enjoy his confidences. Friendship seems to be based on playing and drinking together. In his erotic life, sex and love are separate. Despite this, he is capable of pathological jealousy which is often combined with an intense phantasy life ranging from sheer hatred to wishes to kill the rival or the object of sexual interest. If married, he is apt to be indifferent to his mate and prefer casual extramarital relations or masturbation even when the sexual partner is available. He never attains really adult genital levels of sexual behavior, but is more preoccupied with oral, anal or homosexual trends. Incestual ideas are expressed openly and unrestrainedly, especially when under the influence of amytal.

From the diagnostic standpoint, one of the most important features is pan-anxiety or pan-neurosis. This anxiety pervades all spheres of life, leaving no situation which is free of it. Regardless of how the patient tries to express, avoid or conceal it, the ever-present anxiety manifests itself. In addition to the anxiety, many neurotic symptoms are present simultaneously—anorexia, insomnia and palpitation may exist side by side with various neurotic reactions. The type of neurotic manifestation shifts constantly, but it dominates the patient and is never completely absent. He may appear depressed, but this state is actually better described as "anhedonic" — that is, deriving pleasure from nothing, though the patient tries unsuccessfully to force pleasure from many different situations.

The anxiety may lead to a hypochondriacal preoccupation for which the family physician is consulted. He will be able to distinguish patients of this type from neurotics if he keeps in mind the eagerness with which they describe their symptoms in minutest detail. The borderline schizophrenic is vaguely contradictory, unable to give details and to present symptoms in logical, coherent fashion. Unlike the neurotic who at least tries to rationalize his symptoms or link them to a causative factor, the pseudo-neurotic schizophrenic makes no such attempt.

Some of the psychological tests are valuable in arriving at diagnosis. The Rorschach is particularly valuable, but also the Vigotsky and Goldstein tests pick up thinking disorders which are impossible to demonstrate clinically. However, a number of these people do not show their thinking disorders even on intensive psychological testing.

Amytal interview is also a diagnostic aid which removes inhibitions, releasing actual psychotic material.

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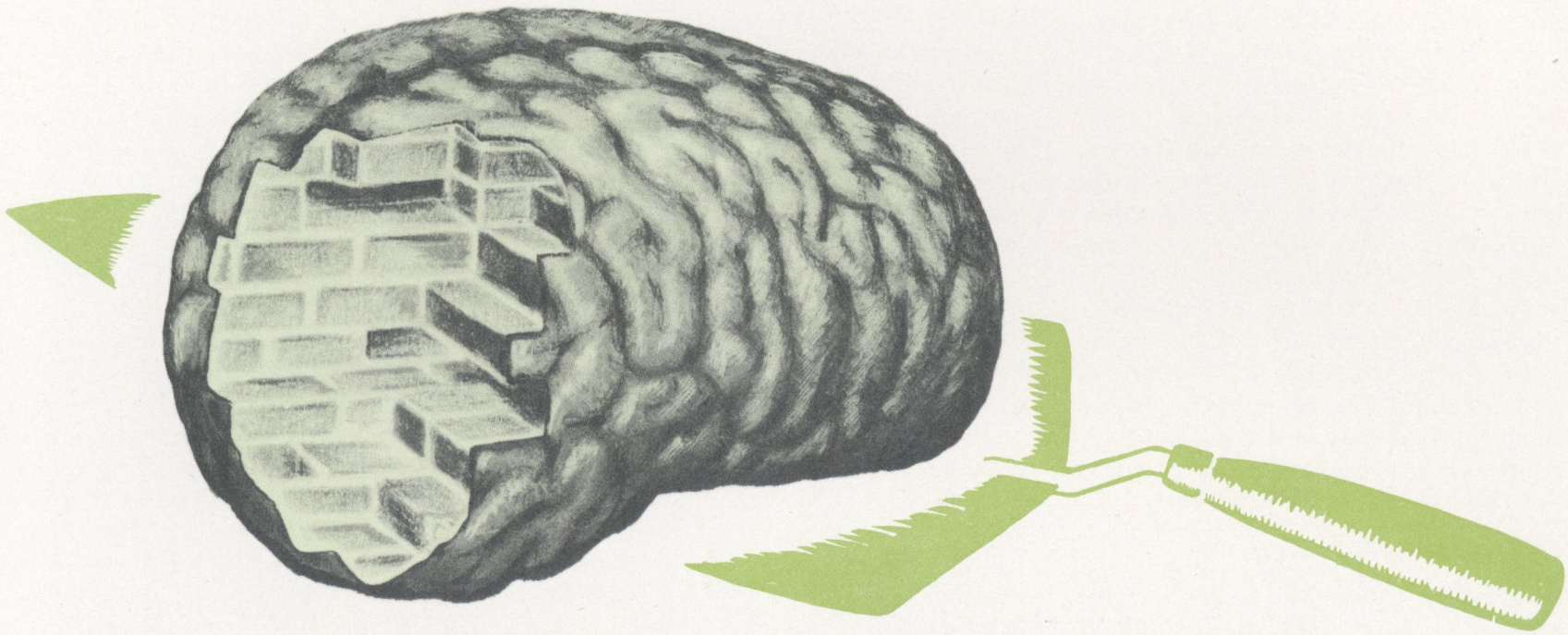


PSYCHOLOGICAL EVALUATION OF

Organic Cerebral Status

THE DIAGNOSIS of pathological involvement of the brain and nervous system is often a difficult task. Such evaluation is of vital concern to the physician, however, since trauma and disease of the nervous system are significant factors in a patient's ability to function adequately as a member of society.

When organic involvement of the nervous system is suspected, the physician may find it useful to seek neurological or psychological consultation. The neurologist can be of assistance in determining *the type of* pathological condition, its etiology and possible sequelae. The psychologist is able to infer *the presence of* a pathological organic involvement of the brain, and its possible effect on the patient's behavior. Properly interpreted psychological studies can corroborate neurological findings and complement them with new insights into the effect of the brain damage on psychological functioning. In some instances, psychological testing provides the first clue to early neural involvement, before overt symptoms of neurological damage appear. In such cases, the psychological report may contain the recommendation that an electroencephalogram be obtained and exhaustive neurological examination performed, thus directing the way to a formerly unsuspected difficulty.

Capacities Affected by Brain Damage

Evidence of organic impairment of the brain makes itself known in weakened functions and altered behavior. The adverse effects of cerebral insult, for example, are discernible on tests of visual-motor coordination. Coordination becomes more difficult for the brain-damaged patient, and peculiar reversal phenomena frequently occur. Even when no interference with visual-motor coordination is obvious on gross examination, impairment may be revealed in tests requiring fine discrimination and precision movements. Both logic and flexibility of thinking are impaired by brain damage. Organic involvement of the brain often results in some loss of abstract reasoning ability and forces the patient to assume more concrete attitudes. The ability to shift from one concept to another as the situation demands is an important factor in problem solving and adapting to new situations. Brain damaged patients often exhibit what has been referred to as an intellectual "stickiness" characterized by a perseveration of ideas. This feature sometimes makes them appear superficially rigid. Organic cerebral damage may make serious inroads on attention span and the ability to concentrate. Speed of response may be slowed and a decreased selectivity in responding to simultaneous stimuli is often in evidence. New learning ability is adversely affected, as is memory function. Recent memory is usually the more seriously depleted but lapses may also occur in past memory. These blank spots may be recognized by the patient or he may unconsciously fabricate material in

order to fill in these memory gaps.

Intellectual functioning is not the only psychological capacity affected by brain damage. Decrease of rational control over emotional responsiveness may also be traced to organic causes. Over-responsiveness to affective stimuli is a common sequel to cerebral trauma.

Seldom do all of the above symptoms occur in any one patient. However, the constellation of symptoms is instrumental in contributing to the diagnosis and may be a valuable asset in arriving at a therapeutic regimen for the brain-damaged patient.

Prognosis

The prognosis of patients with organic cerebral damage depends on the extent of impairment, the anatomical areas involved, progression of the disease, and the abilities which remain unaffected. The psychologist can assist in prognosis by estimating the positive intellectual and emotional resources which remain at the patient's disposal. For example, it is extremely important in the future management of a patient to know how severely an intracranial hemorrhage has affected his ability to analyze and integrate his experience in a rational manner. It is also important to know a child's intellectual efficiency and emotional control following a bout of encephalitis. In general, the psychological impairment associated with nonorganic illness is frequently reversible in character, while the damage resulting from organic deterioration usually is permanent.

Repeated psychological studies over a period of time provide an effective method of determining the arrest or possible progression of neurological disease. After viewing the results of the first examination, the physician may order periodic re-tests. More serious distortion of psychological functions may then be revealed. This constitutes potent indication that the disease process is continuing to take its toll.

A Case History

J. D., a 21-year-old, married farmer, was brought to the hospital by his wife and parents because of peculiar behavior. On one occasion he had slaughtered six laying hens, saying, "They were making eyes at the hogs." He later released the hogs from their fenced enclosure and drove them out onto the highway, claiming he could not "trust them anymore." He had wrecked the family truck when driving to town, and had recently devoted less and less time to reading the newspaper, formerly one of his favorite activities. Explosive aggressiveness was occasionally in evidence. Formerly, he had always been a calm, withdrawn young man.

Before being referred to the psychologist, the patient had been given a complete physical examination which included the usual neurological survey. The only definite positive findings pertained to a bilateral impairment of vision. A short psychiatric screening interview suggested a diagnosis of "psychosis of unknown etiology."

On the first psychological examination J. D. disclaimed any recent changes in behavior, feelings or intellectual ability. He maintained he was going through the medical procedures just to satisfy his wife and parents. The psychological tests, however, gave extensive supportive data to the story told by J. D.'s wife and parents. His visuo-motor coordination was extremely poor and he had difficulty in recognizing and categorizing familiar objects. Abstract conceptualization was totally beyond him; he could not make the simplest designs with colored blocks. His memory was fairly well preserved for all but recent events and he showed excessive difficulty in forming new associations; he was unable to learn new verbal material with any facility. Perseveration of ideas was present; Card I of the Rorschach Ink Blot Test was described by the patient as "a dried up leaf" and all succeeding cards elicited the same response. The only variation appeared on the colored cards, in which he stated that the leaf was "on fire."

The summary of the psychological evaluation suggested strong evidence in favor of a generalized organic disorder and recommended a re-evaluation after several weeks to help establish test reliability and progress of the disease, if any. The patient was kept under daily observation by the neurologist, psychiatrist, and psychologist. During the following three to four weeks the patient received more thorough evaluations by each member of the team.

During the period of observation, gross neurological signs rapidly became prominent. Both vision and hearing showed a marked decrease in acuity. His speech was occasionally slurred. The patient had trouble in maintaining his equilibrium; he began walking with a distinct list to the right. At the time he was retested by the psychologist, nearly every psychological function which is susceptible to the impairing effects of brain damage showed further deterioration. Following the second psychological testing and the completion of extensive neurological studies, a diagnosis of Schilder's Disease, or encephalitis periaxialis diffusa was made. In this instance each member of the consulting team —the neurologist, the psychiatrist, and the psychologist—contributed to the final diagnosis.

In the case of J. D. it was the psychologist's report which gave the first major clues to the type of disorder and pointed out its probable course. As this case illustrates, the psychological study can corroborate the intuitive feelings of the physician and clarify diagnosis in the event of a somewhat nebulous clinical picture.

In neither the clinical psychologist nor his tools can be found any magic or infallible diagnosis of intracranial damage. However, with specialized psychological techniques and careful interpretation of the test findings, the clinical psychologist can be a valuable consultant in the evaluation of neurological disorders.

Suggested Reading

Anderson, H. H., and Anderson, G. L.: An Introduction to Projective Techniques, New York, Prentice-Hall, 1951, Chaps. 1, 2, 3.

Brower, D. B., and Abt, L. E.: Progress in Clinical Psychology, Vol. I, New York, Grune & Stratton, 1952, Chaps. 1, 2, 3, 4.

Dennis, W., et al: Current Trends in the Relation of Psychology to Medicine, Pittsburgh, University of Pittsburgh Press, 1950.

Mensh, I. N.: Psychology in Medical Education, Amer. Psychol. 8:83 (Feb.) 1953.

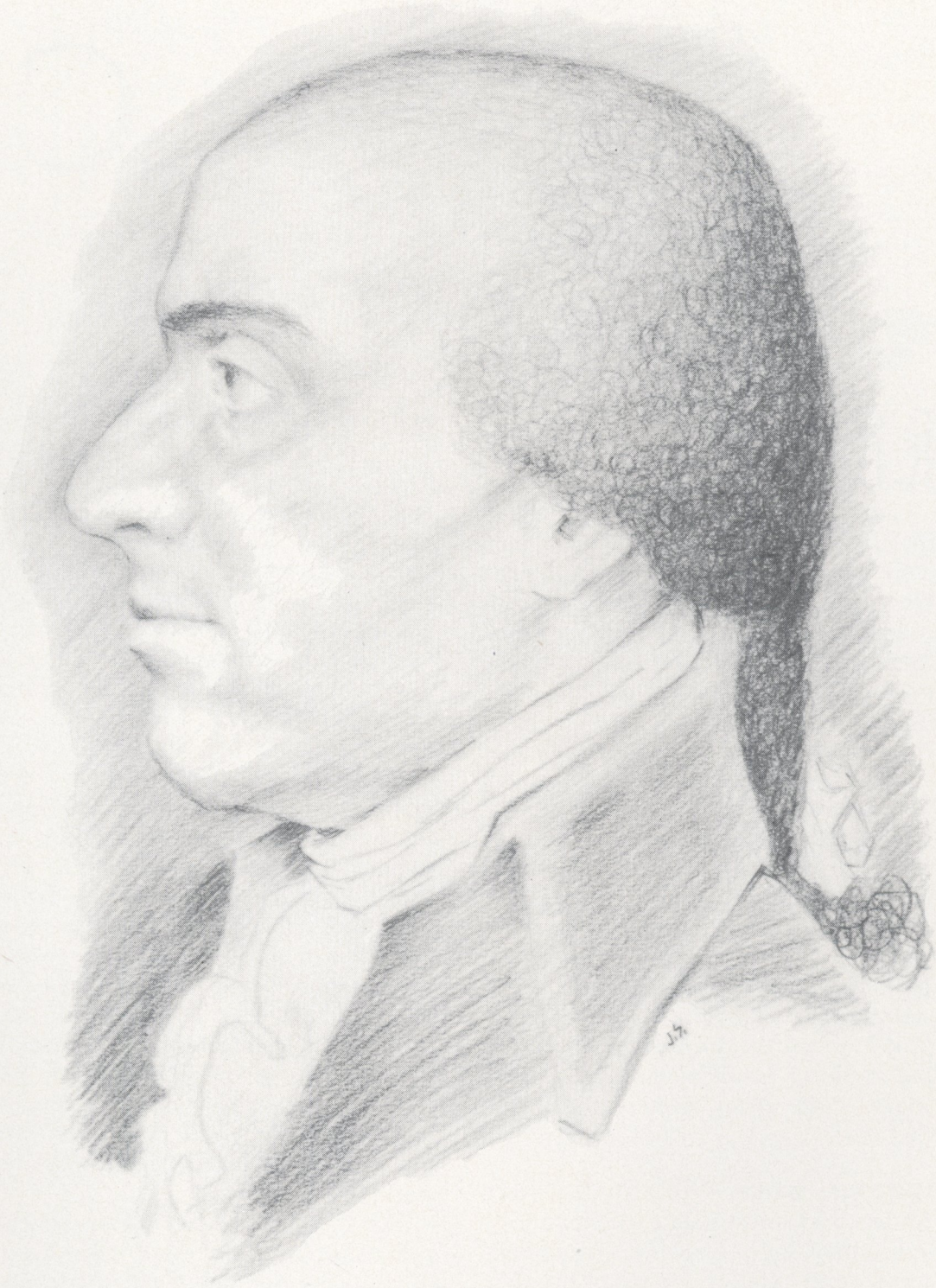
Terman, L. M., and Merrill, M. A.: Measuring Intelligence, Boston, Houghton Mifflin Company, 1937, Chaps. 1, 2, 3.

Watson, R. I.: The Clinical Method in Psychology, New York, Harper & Brothers, 1951, Chaps 1, 2, 3, 17-23, incl.

Wechsler, D.: The Measurement of Adult Intelligence, 3rd. Ed., Baltimore, The Williams & Wilkins Company, 1944, Chaps. 1-6, incl.

Yacorzynski, G. K.: Medical Psychology, New York, The Ronald Press, 1951, Chaps. 1, 2, 3.

RUSH



BENJAMIN RUSH has been termed the father of American psychiatry. He was born in 1745, the same year as Pinel, whose reforms revolutionized the care of the insane in France, and later, throughout the world.

A prominent figure during the American Revolution, Rush was one of the signers of the Declaration of Independence. Yet, he is remembered more for his contribution to the embryonic science of psychiatry.

A generation before, through the efforts of Benjamin Franklin, an act had been passed founding the Pennsylvania Hospital, with a ward "for reception and relief of lunatics, and other distempered and sick poor." Prior to that time, patients who were deemed insane were jailed, sent to almshouses, or left virtually unattended in the various communities. Only upon their hospitalization did it become possible for physicians to subject them to consistent clinical observation and therapy.

Stimulated by the example of Pinel, Rush was eager to do something for the unfortunate mental patients of his day. In this work he pioneered in a pioneering setting, for he began practice in Philadelphia, site of the first medical school as well as the first mental hospital in the new country. As youngest member of the faculty, Rush lectured on mental disorders at the University of Pennsylvania. Subsequently, the material from his lectures was published under the title, "*Medical Inquiries and Observations upon the Diseases of the Mind.*" The volume went through four English editions and one in German, and remained for decades the only systematic textbook in America on the subject of mental illness.

Working as a staff member at the Pennsylvania Hospital, Rush was a firm believer in the theory that

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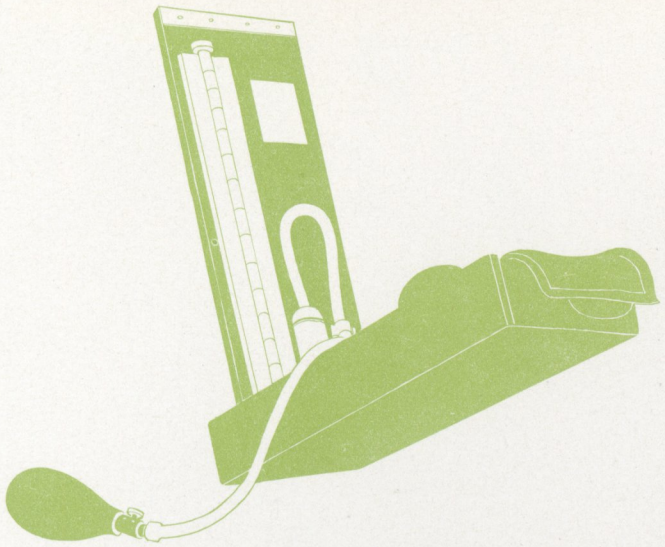


CASE HI

R.B., a 23-year-old female, was admitted to a large teaching hospital in July 1949 because of severe headaches, giddiness, insomnia, and high blood pressure. The systolic pressure ranged between 170 and 190 mm. of mercury and the diastolic pressure between 110 and 120 mm.

PHYSICAL STATUS: Exhaustive clinical studies were carried out, including tests to rule out pheochromocytoma. Urine studies were negative except for occasional traces of albumin, and kidney function tests were within normal limits. Intravenous and retrograde pyelography showed no pathological conditions. Under heavy sedation with sodium amytal, the blood pressure dropped to 145/90, but waking levels remained alarmingly high even after a month's bed rest.

EMOTIONAL STATUS: While studies were under way to evaluate the patient's suitability for a possible sympathectomy, the regular rotation brought a new interne to the ward. He noted the rather sketchy personal history on the chart, and after one or two "get-acquainted" visits with the patient, asked her casually if she could possibly be having any family problems causing her some worry. To his surprise, she burst into tears and after composing herself related an involved and complex story of trouble in her marriage. She had been unable to confide this to the previous interne; he had been a good friend of her husband in college and rarely missed an opportunity to tell her what a "fine guy" she was married to. Besides, she had not supposed that her unhappy home situation could have any connection with the high blood pressure. Psychiatric consultation was thereafter requested.

PAST HISTORY: The patient was the younger of two sisters whose father had deserted the family when she was two years old. In the next five years of her life, she was sent to live with her mother's parents. They were an austere, Victorian couple who were undemonstrative of affection and who tolerated no show of aggressiveness or questioning of their word. The mother worked in another city and saw the girl only on occasional weekends. After five years of this, the mother married a man twice her age and brought the patient back to live with her. This was a turbulent period during which the mother began having open affairs with other men. The patient remembers being taken along on some of the dates, and recalls the mother's contemptuous references to her husband as a silly old fool. The patient, however, was quite fond of her stepfather, and was hurt and grieved when finally he moved out and sued for divorce.

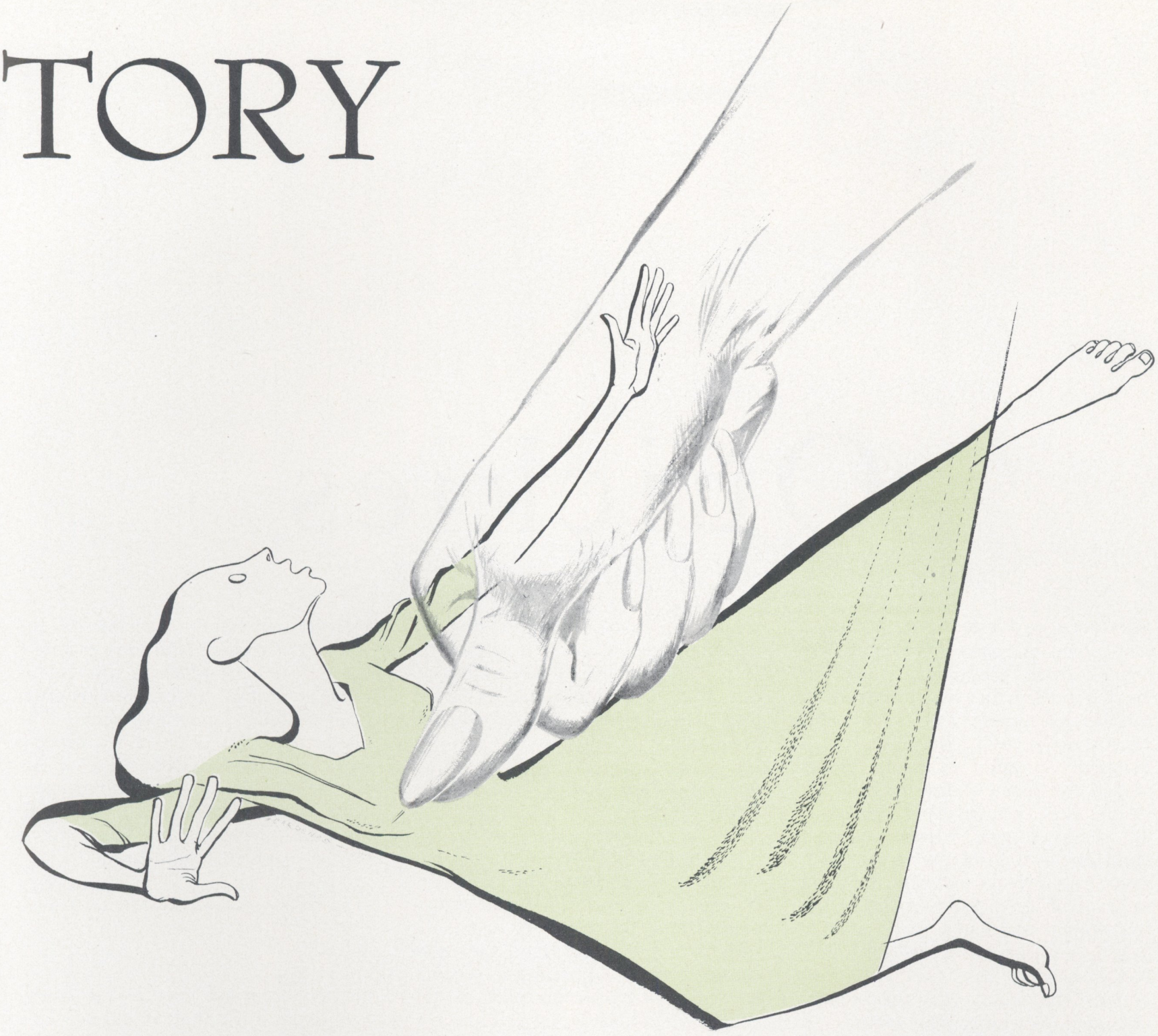
As she entered her teens, she began to become more and more aware of the mother's favoritism toward the older sister. The sister got the new clothes and the patient wore hand-me-downs. The sister took dancing lessons and the patient was told she was awkward and it would be money wasted on her. The patient was rapidly developing into a very attractive young girl, while her older sister was definitely homely. Apparently the mother was an immature person herself and treated her younger, more attractive daughter like an unwelcome competitor. Dates were discouraged and the boys who did come around were treated so rudely by the mother they seldom came back. At seventeen the patient finally met a boy three years her senior, who persuaded her to elope after a two weeks' courtship. The mother was outraged, and let it be known she intended to give her no further support of any kind.

The marriage deteriorated rapidly. The husband turned out to be an extremely infantile person completely under the domination of his mother. He was rather amiable as long as things went smoothly but had violent temper tantrums when he did not get his way. They moved in with his parents, where he made no effort to make things easier for his wife in getting along with the family. His mother was an opinionated, dictatorial person who retreated behind a facade of pious martyrdom whenever she was crossed. When the patient's baby girl was born in the third year of the marriage, the husband's mother assumed full command of raising the child. The husband either sided with his mother or kept silent whenever the patient tried to assert herself.

In this dilemma the patient felt completely trapped. She had a total lack of confidence in her ability to survive on her own, and could not turn to her family. She felt forced to continue the unpleasant arrangement with no chance to vent any of her frustration and resentment.

THERAPY: Psychotherapy was instituted and carried out over a period of some eighteen months. Many other significant facets in this girl's background were worked out in the course of treatment. She began to improve symptomatically soon after beginning therapy. She left the hospital, finding work in a nearby city where she continued treatment as an office patient. Starting as a sales clerk, she took night courses to learn comptometry and ultimately obtained a good-paying job. This was a significant step in establishing her self-confidence and it enabled her —emotionally and financially—to take full custody of her little girl,

STORY



who had been with the paternal grandmother since her admission to the hospital. She was encouraged to work out her own decision about the marriage. The husband refused her offer to try to salvage the marriage on the condition that they move away from his parents. Thereafter, she obtained a divorce.

FOLLOW-UP AND PROGNOSIS: This woman has now been symptom-free for over a year. Periodic blood pressure readings have been taken during that time, and though the systolic pressure has at times been as high as 150 mm., the diastolic pressure has been consistently under 85 mm. She has recently remarried and at last report she was making quite a stable adjustment.

DISCUSSION: Alexander and his associates in Chicago have demonstrated an essentially similar conflict involving repressed hostility or aggression in many hypertensive patients. This patient appears to fit into that group. Although the relationship between elevation of blood pressure and certain emotional states has been appreciated since the pioneer work of Cannon, few people hold that so-called essential hypertension is a completely psychogenic condition. There are undoubtedly important constitutional factors and perhaps inherited variations in the lability of the vascular system.

Despite her dramatic improvement, this patient must be considered vulnerable to possible future hypertension, and should be regularly re-examined. It is worth pointing out that this case illustrates that the diastolic as well as the systolic pressure may be elevated well above normal limits in primarily psychogenic hypertension. Finally, the history of this case demonstrates again the fact that *no diagnostic study is complete that does not include a thorough inquiry into the emotional life of the patient.*

Quickies

MONGOLISM IN ONE OF TWINS: Although mongolism in one of twins is extremely rare, the phenomenon has been reported in the literature a number of times. Two such cases were encountered, however, in a maternity hospital in South Wales within the space of five months.

The first case involved a mother, 37 years of age, whose youngest child at the time of the twins' birth was twelve years old. In the long interval of time between deliveries, the woman had had a series of miscarriages. The twins were a perfectly normal boy, weighing five pounds one ounce, and the mongoloid girl, weighing four pounds 13 ounces. On a regimen of thyroid and pituitary hormones, the mongoloid appearance of the female twin appeared to recede somewhat and the last report was that the child continued to improve.

The second case concerned a 28-year-old woman, the mother of two normal young children before the birth of the twins. Her twins were born under difficult conditions, with labor being induced because of gross eclamptic toxemia. The twins were described as a normal female weighing six pounds nine ounces and a male baby weighing four pounds twelve ounces, with pronounced mongoloid characteristics. Hormone therapy was instituted, but owing to the mother's refusal to permit immunization of the children, the weaker, mongoloid infant died of diphtheria at the age of nine months. In neither case was there any indication that the mother had been exposed to German measles during pregnancy.

Cook, B. A.: Mongolism in One of Twins: Report of Two Cases, Med. J. Australia, 2:445 (Sept. 16) 1950.

THE EGO IN ADOLESCENCE: The adolescent is faced with many difficult adjustments, and the more complex the society in which he lives, the more complex these adjustments become. In primitive tribes, the place of the adolescent is clearly defined and circumscribed, whereas a society based on technical advance requires that the adolescent fit into the pattern of a "miniature adult" in many respects. For example, he is supposed to be qualified at this time to choose his "life's work." He is expected to exercise adult control over the new bodily sensations and often frightening emotions which accompany his sexual maturation. The adolescent needs consistent emotional support and reassurance in this difficult task, both from his parents and from members of his own age group. His desire to win the approval of his family is supplanted to a large degree by desire to win approval of his contemporaries. Therefore, his associates are quite significant in the development of new patterns of behavior. Pressures exerted on the adolescent require him to re-evaluate himself and his place in life. In his effort to do this, his behavior is often unpredictable and confusing. The adolescent who is aided by sympathetic attitudes on the part of his family and constructive experiences with his contemporaries is strengthened and abetted in his development toward a normal adulthood.

Josselyn, I. M.: The Ego in Adolescence, Read at the 109th Annual Meeting, APA, Los Angeles, May 4, 1953.

INDIVIDUALIZING THE CARE OF THE AGING: Emotional difficulties in older people are often precipitated by fear of losing their independence and their sense of individuality. Long before they become actually incapacitated, many elderly persons are relegated to the role of being merely "someone's grandmother," and feeling relatively useless in a corner of the home. Enforced retirement proves costly, not only economically, but also in terms of their self-respect. Thus, many of the problems of aging are not inevitable, but imposed by society. Increased recognition of the usefulness of the aging individual would forestall many tragic examples of personality disorganization among the elderly. The morale of members of the older age group should be maintained wherever possible, through interesting hobbies

and productive work. Many of the problems incident to the growing population of older people could be minimized if provision were made for recognition and opportunities for aging individuals consistent with their capacities and desires.

Clow, H. E.: Individualizing the Care of the Aging, Read at 109th Annual Meeting, APA, Los Angeles, May 5, 1953.

EMOTIONAL FACTORS IN CHILDBIRTH: "The biggest single factor in determining ease of childbirth is whether or not the mother is able to accept the child." So stated H. K. Hall, M.D., of Dalhousie University, Halifax, Nova Scotia, speaking before the panel on Mental Hygiene at the annual APA convention. Dr. Hall reported the results of a study of 124 parturient women, who were interviewed regarding their attitudes to their pregnancies and their prospective offspring. Women who experienced a minimum of fear came through delivery with little difficulty, as did women who were emotionally stable and who regarded themselves as healthy. The attitude of the husband to the expected child was of considerable importance in lessening emotional unrest in the prospective mother. Since psychological equanimity is of such vital importance to the successful outcome of confinement, the investigator feels that many women can be helped to an easier delivery if they receive assistance and emotional support during pregnancy, aimed at modifying any unhealthy attitudes they may possess.

Hall, H. K., and Crook, A. J.: Emotional Factors Relating to Performance in Childbirth, Read at 109th Annual Meeting, APA, Los Angeles, May 6, 1953.

THE RIGHT OF PRIVILEGED COMMUNICATION: Since a physician cannot treat a patient effectively without full knowledge of the pertinent facts relating to his disability, it is important for the patient to know that his disclosures will be held confidential, even in the courts of law. This is particularly true in psychiatric illness, in which publication of certain details might prove damaging or humiliating to the patient concerned. Statutes insuring the right of privileged communication in the state courts now exist in 31 of the 48 states. In 22 of these states, the privilege of professional silence applies in civil and criminal cases alike. In California and several other states, the privilege applies for civil cases only. In the event of a criminal trial in the federal courts, however, the privilege does not exist, and physicians may be legally compelled to give testimony obtained in a confidential interview.

The right of privileged communication is limited to confidential information and to matters essential to medical consultation and treatment. Communications made in the presence of a third person are not classed as "confidential" under this ruling, unless the third person is a nurse or an attendant necessary to the medical procedure.

Physicians who deal with a high preponderance of mentally ill patients recognize the need for this safeguard in their patients' behalf. Nevertheless, legal authorities view the matter from a different perspective and sometimes complain that the right of privileged communication interferes with the administration of justice. An examination of the cases which have called forth such complaint reveals that most of the so-called abuses of this right stemmed from lawsuits involving personal injury.

The physician's exemption as described above applies to testimony in court. It does not, of course, obtain in the rendering of reports required of the physician by statutes governing such matters as certificates of life and death, contagious disease, violent injury, or the treatment of a narcotic addict.

Perkins, R. M.: Legal Evaluation of Problems of Privileged Communications, read May 6, 1953, at 109th Annual Meeting of the American Psychiatric Association, Los Angeles, Calif.

Regan, L. J.: Medical Civil Problems of Privileged Communications, read May 6, 1953, at 109th annual meeting of the American Psychiatric Association, Los Angeles, Calif.

"malingering

"Everything went black."

In fact and fiction, the above statement has become a pat and familiar excuse. The person employing it often hopes to benefit thereby. The gain in the offing may be avoidance of criminal responsibility, escape from distasteful duty, or monetary compensation for some alleged injury. Not infrequently, the physician is called upon to evaluate the veracity of such a claim. His opinion may be sought as to whether an apparent loss of function is real or feigned. Or, he may be asked forthright to determine whether or not an individual is malingering.

This is hardly a welcome assignment for a member of the medical profession, since ethical connotations such as "cheat" and "fraud" are not commonly within his province. Yet, simulated illness occurs more often than one might suppose. That is why malingering, although not a disease entity, is nevertheless considered an important aspect of forensic medicine.

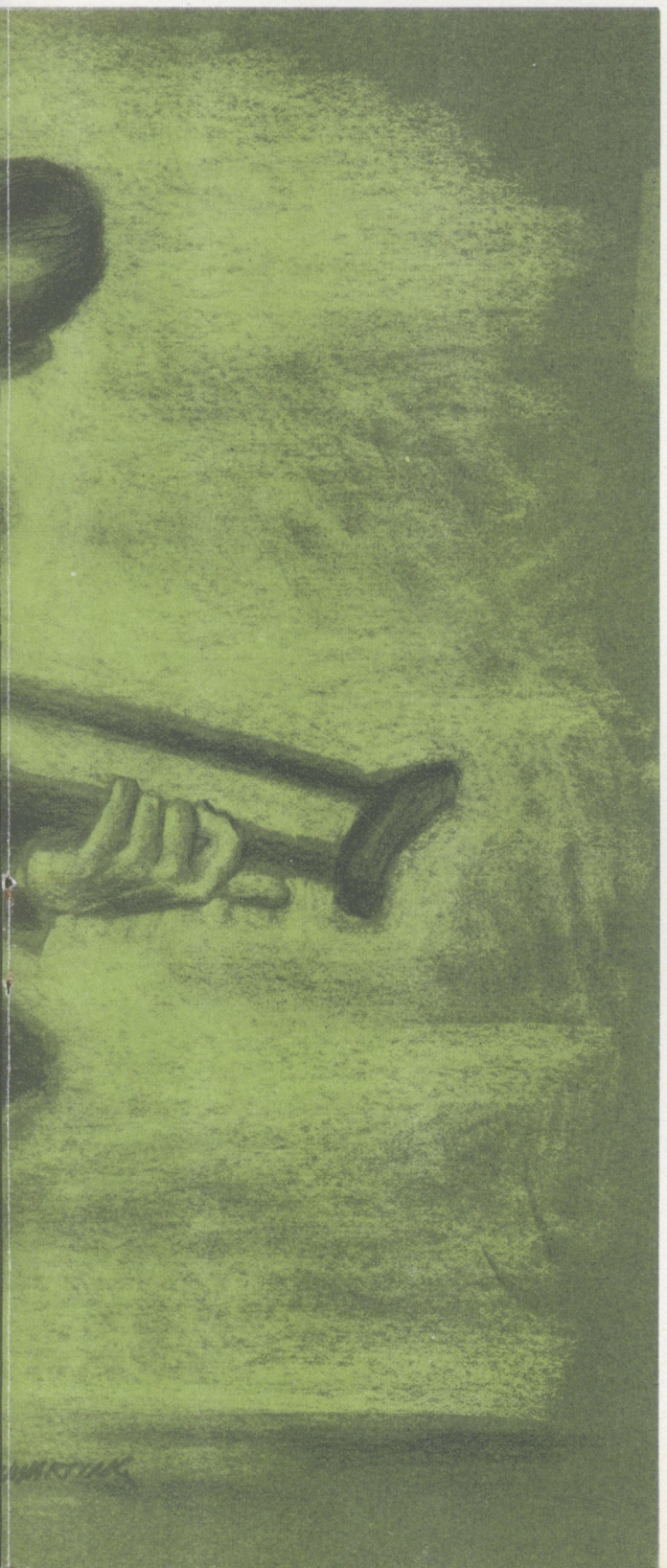
No label of "malingering" is justified until one has ruled out actual disorder. Both physical and psychiatric conditions can be malingered.

Mental derangement and mental deficiency have been deliberately imitated. In addition, certain symptoms of disordered function may be malingered. In these cases, proof of malingering is rendered more difficult because identical symptoms of disordered function may prevail in

certain neurotic reactions when no actual organic disease is present.

The Malingerer Versus the Psychotic

Dread of psychiatric commitment tends to discourage the malingering of psychosis except in extreme situations, such as the defense of persons accused of capital crimes. When psychosis is malingered, the picture of abnormality is frequently overdrawn. The average layman without specialized training often has an erroneous impression of psychotic behavior and therefore overemphasizes the bizarre and bestial manifestations. When a defendant facing possible execution presents as his total syndrome "making like a bear, an ape or a wolf," there is more than a moderate cause for suspicion. Usually, in such instances there is ample opportunity to observe the subject, since defendants under capital indictment are not granted bail. Psychological tests, particularly of the projective type, are frequently of value in unmasking the pretense of psychosis. When human life is at stake, the final diagnosis is carefully thrashed out by specialists in psychiatry and the law.



The Malingerer Versus the Mentally Deficient

The prevailing rule of criminal responsibility decrees that before he can be held culpable, a defendant must understand the nature and the wrongness of his act. For this reason, there have been attempts to malinger mental deficiency. If the individual is a genuine defective, there is usually some evidence available in the life history. This information is commonly obtainable from school and vocational records. Even though material from the personal history is lacking, it would be difficult for the malingerer to control the results of psychometric testing. Any effort to do so is likely to produce an uneven performance, since the untrained individual is not aware of the age-level which each question represents. In the absence of schizophrenia, a wide divergence in the test scores is adequate cause for suspicion of malingering.

The Malingerer Versus the Neurotic

The physician may find some difficulty in distinguishing the malingerer from the neurotic. In both, claims of disability refer to symptoms, rather than disease entities. And, of course, a symptom can be indicative of many different disorders. Amnesia is a typical example. Before one is justified in charging that amnesia is malingered, it is necessary to rule out the conditions which cause actual loss of memory. Among these are dissociative reaction, epilepsy, head trauma, and alcoholism. The latter three usually are distinguishable through physical diagnostic measures. That leaves the memory gaps of dissociation which still must be differentiated from malingered amnesia.

Dissociative Reaction with Amnesia

A singular feature of amnesia is the rational appearance and conduct of the subject in his dissociated state. It is perhaps this fact which accounts for widespread claims of amnesia for avoidance of criminal responsibility. However, those who malinger amnesia in an effort to escape culpability are commonly misinformed on the law. For amnesia, even when genuine, is not necessarily a valid legal defense. If it can be demonstrated that the individual *acted as if* he knew he was doing wrong, his action is culpable, even though he was in a state of trance.

From the medical viewpoint, it may be borne in mind that amnesia is unlikely to appear suddenly in the absence of acute infection or trauma, unless there is long-standing emotional conflict in the life of the individual. This conflict often becomes apparent in the behavior seen in amnesic states. For example, the guilt-ridden, faithless wife has been known to flee from her lover, and the reluctant family man has found himself in a strange city many miles from home. In contrast, the background of the malingerer is likely to include antisocial behavior, rather than intense emotional conflict and frustration. In genuine amnesia, the loss of memory obtains for all particulars. Not only damaging evidence, but also items which might materially aid his defense, are forgotten. Conversely, Davidson describes malingered amnesia as "both patchy and self-serving."

Loss of memory is not the only disordered function that may be simulated for gain. Symptoms of physical disability are also claimed. Indeed, detection of the malingerer would be far simpler were it not that many complaints he consciously feigns are also achieved unconsciously in neurotic disorders. These are the symptoms commonly encountered in the conversion reaction, formerly referred to as hysteria.

Conversion Reaction

In their arrested functioning, both the malingerer and the conversion neurotic offer presenting symptoms which provide escape from unwanted life situations. Although they mimic true physical disorders, their imitation is a crude one, since the area of "malfunction" does not coincide with the actual distribution of the nervous system. Nevertheless, the

neurotic is self-deceived, so in fairness his behavior cannot be regarded as fraudulent.

Strecker has said the conversion reaction is like "closing the eyes to escape the bogey man." Indeed, blindness is one of its most familiar manifestations. Sudden onset of protective blindness is an established occurrence among soldiers under combat stress. The psychiatric explanation is that intolerable conflict between their desire to stand and fight and their desire to flee becomes too great to cope with. This conflict is said to become converted into the physical symptom which relieves them of the problem at hand. That this blindness has no organic basis can be established by checking involuntary reflexes, such as blinking when something is passed before the eyes, or pupillary adaptation to light. Although the symptoms employed in conversion reaction may take many different forms, such as paralysis, anesthesia, mutism and deafness, in each intance some conflict which produces grave anxiety lies at the root of the bodily inhibition.

A clue in the diagnosis of conversion symptoms may be found in the patient's history and personality type. The typical "hysteric" tends to be impulsive and immature, highly sensitive and imaginative, with leanings toward dramatic forms of expression. His background often reveals prolonged periods of emotional frustration and distress. This type of individual is usually cooperative and welcomes the ministrations of the attending physician. Search for a precipitating incident often reveals that an emotionally-charged situation is involved. Once the purposeful nature of his illness is clear to him, the patient may respond with a sudden change of symptoms. With improved capacity for handling the conflict-provoking situation, the patient may find that the symptom is no longer needed for his purpose.

In contrast, the malingerer who falsifies organic illness is in a much weaker position in his attempts to deceive the examining physician. Sensing this, he adopts an uncooperative attitude, in which hostility and suspicion are readily apparent. If he claims that he cannot see, he is likely to become unnerved upon being informed that "the pupils respond normally to light." If he says he has a paralyzed arm, a device the physician may employ is to raise the "afflicted" arm and ask the patient whether he is able to push it down. Trying to show that he cannot, he may partially support the weight of the arm—a thing he could never do if the member were actually paralyzed. Being confronted with this discrepancy may confuse and embarrass the malingerer, whereas it will not disturb the neurotic who is not consciously trying to deceive the physician. There are countless such ways in which an alert physician can unmask the malingerer, provided he will take the pains to fit his experiment to the individual case. That many physicians fail to do this is evident from the disclosure of the Robins survey that 26 per cent of one group of patients with conversion reaction had been labeled malingerers by at least one attending physician.

Traumatic Neurosis

One factor that looms high in the perpetuation of symptoms is that of secondary gain. Monetary compensation, for example, is sought by neurotic and malingerer alike. In many cases, such "benefits" are particularly conducive to the prolongation of illness following either physical or emotional trauma.

In the normal individual, reaction to trauma is reversible and short-lived. But in certain neurotic individuals the reaction following trauma is characterized by undue anxiety, dependency and shrinking from contact with the external world. He "puts off the day when he must return to work and his whole life seems to revolve around his injury." This is often one of the most stubborn problems in the physician's entire practice.

Some neurotic patients become so beset with the need to feel secure that they undervalue a large earning capacity in favor of a small disability allowance. Davidson cites the example of one of his patients who earned $12,000 a year in his job. Yet he permitted himself to be carried as a neurotic by the Veterans Administration for $15.00 a month partial disability. When asked his reason for this, he explained that "whatever happens" this monthly stipend would take care of the premium on his life insurance. This shows how pathological feelings of anxiety are precariously held in check by a concrete symbol of security.

Far from knowingly perpetrating deceit, the patient with traumatic neurosis unconsciously prolongs his symptoms to prove he is being honest. No such scruple disturbs the confirmed malingerer. Nevertheless, the point at which unconscious motivation ends and conscious malingering begins is often indistinguishable. Over a period of time, however, a characteristic pattern will usually emerge in the manner of response to medical care. The neurotic shows retardation both in work and play, whereas the malingerer will tend to find room for some pleasurable pursuits. The neurotic will ordinarily accept work, provided it does not involve use of his "afflicted" parts, while the malingerer tends to shirk work of whatever kind. Usually the neurotic is more conscientious in following his clinical regimen and submits willingly to mental observation or even surgery. The malingerer is not eager to cooperate to this extent. Under prolonged observation he is prone to reveal belligerent and anti-social attitudes and may prove deceptive in areas other than his alleged illness.

Probably the shrewdest malingerer reported in the literature was a veritable "Johnny Appleseed" reported by Bender. He had been diagnosed schizophrenic because of his claim that he heard voices. These "voices" quieted down each spring, and so did the patient, who thereby obtained his release to wander the countryside during the balmy summer months. But with the first snow, Johnny and the "voices" invariably sought asylum in a mental institution, picking out a different one each year. His "voices" must have been saying, "Be good to yourself, Johnny, be good to yourself."

Suggested Reading

Bender, N. J.: Malingering, New Orleans Med. and Sur. J. 103:71 (Aug.) 1950.

Davidson, H. A.: Forensic Psychiatry, New York, The Ronald Press, 1952, Chaps. 1, 4, 11.

Ed: Compensation Complex, Psychiatric Bulletin 1:60 (Summer) 1951.

Robins, et al: "Hysteria" in Men, New England J. of Med. 246:677 (May) 1952.

Strecker, E. A.: Fundamentals of Psychiatry (4th Ed.), Philadelphia, J. B. Lippincott Company, 1945, pp. 39, 56, 160, 233, 277.

Psychiatry & the Practice of Medicine

By William C. Menninger, M.D.

The following article is excerpted from a talk by Doctor Menninger before the Alumni of Cornell University Medical College April 18, 1953, and published in the Bulletin of the Menninger Clinic © for September, 1953. It is reprinted here by special request of some of the readers of The Psychiatric Bulletin.

Not many years ago, the majority of doctors were general practitioners. In this age of specialization in the field of medicine, there have been recurring statements that the "family doctor" is a vanishing species. The fact is, however, that many physicians, particularly in smaller communities across the country, still are general practitioners. There are many others who partially limit their practice to one specialty, but also perform some surgery, manage pneumonia, deliver babies and look after the exanthemata in a very creditable fashion. Even so, one gains an impression that they fill the older and glorified role of the "family doctor" much less frequently. Many factors in our cultural living have brought about this change.

The family doctor took more time for his patients than we think we have available in a modern medical practice. Whether he had it or not, he took time to "listen to the patient's story." Rarely did he try to see as many patients as many of us do in our offices today. By making more home calls, he saw the patient's environment. Since he saw more of the family as a unit, he became the doctor of the family rather than the doctor of one member of a family. This is unusual in the current practice of seeing most patients in highly professionalized offices or on the impersonal wards of hospitals. The family doctor did not have an office nurse or social worker who was skilled in taking a history. Nor was he trained to be so dependent upon gadgets and laboratory diagnostic aids; he had to be more self-sufficient.

In speaking of the change in medical practice in terms of the general practitioner or our increasing specialization, I do not decry the present trend. On the contrary, research within specialization has probably brought us our greatest gains in medical knowledge. Nevertheless, I think it would be wise to see what were the special benefits of the methods of the family physician that we no longer use, or at least tend to lose sight of in our present manner of practicing medicine. I dare to suggest that if we were able to impart the increasing knowledge and experience we have gained in the field of psychiatry in

a useful way to all practitioners of medicine, they might recapture some of the qualities, perhaps some of the most effective assets, of the old time "family physician."

From experience and practice in psychiatry, we have learned much about human behavior that increases our understanding of healthy as well as ill people. We can now make comprehensible medical observations which formerly had been incomprehensible. We now have a scientific basis for the interpretation of attitudes and behavior, reactions between people and toward things. Research and experience have led to an increasing agreement about many principles underlying the diagnosis and treatment of mental illness. In retrospect, we can see that some of these principles were used intuitively by the family doctor. My assumption is that most, if not all of these can be used in all branches of the practice of medicine, whether it be general or specialized. Going further, were these principles accepted and applied by all physicians and adapted to their special situations, the result would be a more effective and scientific brand of medical practice. I should like to call attention to some more important of these basic tenets.

Acceptance of the Validity of Psychological Data

Almost from its beginning, scientific medicine has focused its attention on man as an anatomical-physiological-chemical unit. For too many years, the study of human behavior was not included in medical education and practice. Even yet, the medical curriculum includes no courses in physician-oriented psychology, sociology or anthropology. The result is that, in general, physicians have interested themselves in the misbehavior of the stomach and the pancreas, but not in the misbehavior of the total organism in relation to its environment.

It is true that within the last decade certain terms and phrases have been coined to urge the doctor to concern himself with the total individual and not merely with one malfunctioning organ. For example, "treat the person and not the disease"; "study the individual as a whole"; "practice comprehensive medicine."

Despite these admonitions, the average physician did not know how to follow them. He fell back on the

pragmatic orientation of his medical education. He diagnosed and treated a disease or the malfunctioning of an organ or system. Even today, many physicians are baffled by the patients in whom they find no organic or chemical pathology—and, those are conservatively estimated to be fifty per cent of all patients. When they can find "nothing wrong," they resort to platitudes or placebos because they do not know what else to offer. Until recently, the medical student was given no scientific method for evaluating or dealing with psychological and sociological factors in the patient's incapacity. More significantly, he was given to understand—by precept and example—that psychological and social data were irrelevant. He was taught only that if no pathological organic condition was found, the patient was not sick; the patient only *thought* he was.

On the positive side, medical education has greatly improved in this respect in the last ten years. There is an increasingly helpful body of knowledge, widely disseminated, regarding the power of the emotions acting on the soma, even to the production of organic disease. There is more awareness on the part of physicians of the etiological significance of social factors, of the direct bearing that interpersonal relationships have on the cause and course of an illness, and of the high degree of specificity of psychological supports and stresses for each individual. One of the fundamentals of psychiatric practice, applicable to all medicine, is the assumption that psychological and social data are just as valid and of equal importance in the diagnosis and treatment of most illnesses, and of greater importance in many, than are the anatomical, physiological and chemical data.

The Concept of Personality

Because of the acceptance of the validity of psychological and social data, the psychiatrist investigates all aspects of the total person—physical structure, body chemistry, psychological life, and social relations. These are all interrelated and interdependent parts, so that every reaction to a stimulus, whether it originates within or without the body is a composite of the responses of the various segments of the person.

Psychiatry is then, in a very real sense, "comprehensive medicine." Its investigation can never be limited to a particular set of organs. Nor can any physician with a psychiatric point of view see his patient as being merely a case with an abscessed liver or a gun shot wound of the femur. The other specialties of medicine *tend* to deal only with parts of a person—the chest, skin or bones, heart. Psychiatry, as should all medicine, deals not only with the pathology of the physical being, but also with the pathology of the psychological life and the social environment. If and when its point of view of the total personality can be inculcated in the medical students, one may expect a major revision in attitudes and procedures in the practice of medicine.

The Physiology of the Personality

Physical life depends in essence on an energy system. It is a continuous cycle of anabolism and catabolism. Similarly, psychological life is a struggle between two opposing energy forces, one a hostile-destructive-aggressive drive, and the other a loving-constructive-erotic drive. The ego portion of the personality has the function of controlling and modifying the primitive expression of these energies into socially approved behavior, and of so fusing the two drives in the mature, healthy adult, that the undesirable aspects of each are neutralized by the other.

The ability or inability of the conscious portion of the personality to manage these primitive energy drives determines one's attitudes and behavior. There are many different methods that the personality uses to control and direct this energy, which are collectively identified as psychodynamic mechanisms. Thus, for instance, unconscious hostility, which is prevented by the conscious portion of the personality from being expressed. may be turned upon the self in the form of precordial pain or hypertension.

Therefore, a working knowledge of these psychodynamic mechanisms is essential for the physician to have in order to understand "functional" somatic complaints and symptoms. When we see incapacitating effects of the emotions on the soma, we need to seek out the emotional component. Not only is the physical physiology complicated, but one is dealing with an equally complicated psychological physiology.

The Homeostatic Quality of the Personality

A fundamental of psychiatry, as it is of all medicine, is that any organism tries to maintain homeostasis. This is true of an individual cell and of the most complicated organ. In emotional and mental illness, the development of a symptom or syndrome—be it an illusion, headache or a behavior disorder—represents attempts by the individual to maintain his homeostasis. In other words, symptom formation is an attempt at "self-cure," a way of coping with some internal need or conflict or pressure.

The maintenance of psychological equilibrium requires us "to rise to the occasion," to adjust to a new experience, to mobilize support when under great stress.

The acceptance of this homeostatic principle as applicable to an interpretation of mental and emotional distress is sometimes difficult for the physician. This is due, in part, to faulty medical education, i.e., ignorance, but also, in part, to the physician's own emotional reaction to a particular patient or type of patient. I remember well the unscientific attitude that seemed to prevail on the medical service where I interned. It was made quite clear to me by certain attending physicians that I should discharge patients with functional illness quickly. They wanted the beds for "more interesting" cases. Many times I have heard physicians confess frankly that they did not want to be bothered with "neurotic patients," failing to realize that all patients, in fact all people, are neurotic in some degree. It is much easier to ignore than to study about what we don't understand.

If the physician would keep in mind this homeostatic principle, it could help him remain objective and scientific in his evaluation of psychological and social phenomena.

Whether the symptom be a fear of tuberculosis (external), or a phobia of heart disease (internal), it reveals the patient's difficulty in maintaining homeostasis. These reactions are

just as automatic and as unconscious as is the mobilization of phagocytic leucocytes in an infected area. They both represent the organism's response to a threat.

The Development of the Personality

The adult personality is very largely the result of two factors: The inherited characteristics, and the effect of relationships and experiences during infancy and childhood. It is believed that along with physical traits, certain psychological characteristics are inherited, such as intelligence and special abilities. Knowledge of these inherited factors is still limited and somewhat controversial. There is, however, no longer disagreement among psychiatrists about the importance of the environmental factors of infancy and childhood in the molding and shaping of the personality.

The events and relationships of these very early years are factors which determine the nature of the adult personality—as the child learns or fails to learn how to relate himself to people; as he learn to accept frustration easily or with difficulty; as he learns or does not learn to accept reality and to conduct himself in a socially approved fashion.

The development of the personality in these early years is an extremely complicated process. For example, the system that is used and the relationships that are formed in the process of infant feeding are probably major determinants of the pattern the child will always use in his manner of receiving or accepting, his reactions when he does not receive, his ability to respond appropriately when he is loved. This experience and subsequent ones of equal importance determine eventual methods an individual uses to gain security and satisfaction, as well as how he relates himself to those about him. In a way, the laws which govern psychological experience are comparable to the facts learned in embryology. Very minor experimental modifications produce an infinite variety of partial or complete arrests, defects, and anomalies. The experiences and relationships of infancy are comparable modifying influences on the young personality.

Psychological maturity is directly related to the pattern of the development of the personality. Information about various types of arrests and immature physical development is known to every physician. Much less well understood is the concept of psychological maturity and how to recognize psychological deficiencies and distortions. A physician should know that normal psychological development of the infant proceeds from an initial 100 per cent investment of interest in the self, to a child's interest in those of his own sex as well, and eventually to the adult's interest in the opposite sex as well as in himself and those of his own sex. Similarly, it proceeds from complete dependence to independence; from gaining greater satisfaction in receiving love and attention to gaining greater satisfaction in giving love and attention to others.

Psychological maturity is frequently unrelated to intellectual or physical maturity, i.e., an individual may be an intellectual genius, but quite incapable of relating himself happily to other people. A man may be highly successful as a business executive and yet be incapable of adjusting to marital and family life. Thus, a person may be mature in one respect and quite immature in another.

The degree of psychological maturity also varies. When all goes well and neither internal nor external pressure or conflict is excessive, it is easier to behave in an "adult" manner. When excessive fatigue or illness or work complications or a love affair presents unusual stress, sometimes the personality will regress temporarily to a lower level of maturity.

The complicated nature of the personality and the experiences to which it is subjected determine its capacity for adjustment. Therefore, how it develops has a direct relationship to the various kinds of partial or complete failure in adjustment which we call illness or disease.

The Role of the Environment

Environmental factors play an extremely important role in the causation of disease, beyond merely the invasion of bacteria or bullets. Through his experience with his early invironment, each individual develops his own methods of coping with the external world. Out of his experience and knowledge grows his special pattern of reaction. Those individuals whose early efforts to achieve security and satisfaction were unsuccessful, develop personality defenses that are mildly or grossly pathological. They resort to the chronic use of neurotic mechanisms, to withdrawal or flight, even without excessive stress.

On the other hand, even the best integrated personalities, if subjected to sufficient environmental stress, develop varying degrees of personality decompensation. This phenomenon was repeatedly observed in combat situations during the last war. Undoubtedly the same situation, however, can exist in civilian life. Either because of highly specific stresses, or because of prolonged severe stress, some aspect of the total personality misfunctions. This can be either in the psychological or the somatic sphere or both.

It is difficult for some physicians to take into account these psychologically and socially noxious influences. Medical training did not include their evaluation, but as their importance was recognized, social casework was introduced to assist in collecting these data. The old family doctor must have had a great advantage over the physician of today in having direct contact with the environment of his patients. He was aware of the intrafamily cohesions or frictions. He was in a position to share the joys and sorrows of his patient's family and see how they affected each member in it. In psychiatric practice, it is always as important to learn about the social environment of the patient and determine what can be done about it in a therapeutic way, as it is to consider the patient's personality. This probably should be equally true of a majority of the patients whom every physician sees.

The Concept of Illness

If we are to consider the psychological and the social aspects of our patients, it is obvious that we cannot limit the concept of disease to an anatomic-physiologic-chemical or mechanistic disorder which is localized in one part of the individual or affects one bodily system. The tendency to do this is still reflected in our system of nomenclature.

Confusion is confounded when the neurologist looks at the patient with his telescopic lens, the internist with his, and in turn the hematologist and the pathologist with theirs. It is a fallacy to believe that one can describe the total picture of incapacity of a social-psychological-biological unit strictly in terms of cellular changes in one small part of it. But to do otherwise *is* difficult.

My brother presented this problem as follows: "What shall we call the 'disease' represented by a man who has always been frail but has worked very hard to support his widowed mother, did not feel he could afford to get married, buries himself in the details of a complicated job, develops paralyzing headaches, loses time at the office for which pay is deducted from his wages, worries about this so much that he loses sleep and begins vomiting after each meal? Just to make it complicated he has a leukocytosis and an enlarged spleen. Does not such a disease defy diagnosis?... Even in the simplest case it seems ...misleading to make a diagnosis in the old-fashioned way. A middle-aged puritan spinster appears in my office with a chancre on her lip. Isn't that a simple diagnosis? I don't think so. Nor would you if I told you the circumstances of how she acquired that chancre, whom she acquired it from, how she happened to select that type of man or why she had permitted him to kiss her. Her sickness cannot be accurately diagnosed as just primary syphilis. She did not come to me because of it. What she came to me for was a more serious thing. She was so depressed about the implications of the infection that she now wanted to kill herself. What is the name of that disease? What is the diagnosis in a patient who has coronary symptoms because he takes his wife to a party? In a woman who has migraine on the weekend that her son is home from college? What kind of arthritis is it that becomes activated with each quarterly meeting of the Board of Directors?"

It is not to deny the practicality of the use of our nomenclature that I raise this point. Rather, it is to emphasize the fact that we have been trapped, because of medical evolution into a concept of disease as affecting *an* organ or *a* system. In our own psychiatric practice, in order to telescope our findings in diagnostic terms, we found it necessary in every case to make three diagnoses — physical, psychological and social. Only by such a system could we describe the person rather than merely his disease.

Interpersonal Relations

Finally, the most important fundamental tenet in the practice of psychiatry is the recognition of the

W. C. MENNINGER, M.D.

emotional interchange between the physician and his patient. In psychiatry, as well as in every other form of medical practice, the physician's personality is one of, if not *the* most potent therapeutic tool he can use. Perhaps the family physician recognized intuitively the good or bad therapeutic effect of his interest, his guidance, and his devotion to both the patient and his family, and, in turn, the patient's affection for and confidence in his doctor. This physician-patient relationship has become the subject of many serious studies by psychiatrists. This is particularly necessary in psychological medicine if we are to handle physician-patient relationships in the most therapeutically effective way.

Patients come to doctors with many different attitudes. Often they are fearful. Some come expecting magic. Sometimes they come only to please someone else. Sometimes they come in to be defiant. They may come because they want corroboration, or to obtain sympathy and attention, or to be told what to do. Some even come with the intent to deceive the physician.

On the other hand, the physician himself is a person with his private prejudices, defenses, blindspots, ignorance. These can be reflected in excessive tests and examinations. Sometimes his uncertainty is expressed in his use of platitudes or placebos, or a know-it-all attitude. Some physicians do not have the courage of their convictions. Others are not sure how to explain or interpret a finding. Too often they ignore the patient's effort to describe his symptoms and are too impatient to be on with seeing the next case to inquire about environmental problems.

This interpersonal relationship is one of the salient points of all psychotherapy. Whether he knows it or not, every physician uses psychotherapy. It may be good or bad, depending upon his attitudes, actions and reactions, his conduct, his ability to listen, his knowledge in knowing what to say and when to say it. If and when psychiatric knowledge of this all-important phase of professional work can be imparted more adequately and more clearly to medical students, we can expect a further improvement in the practice of medicine. It is a part of the "art" of medicine but now much of it can be taught.

To conclude, my attempt to present briefly some of the basic tenets of psychiatry has been motivated by an impression, a belief and a conviction. My impression is that much of this information is not commonly known to many physicians. My belief is that many of these principles are not utilized in daily practice even by many of those physicians who know about them. My conviction is that if they were applied as universally as is our knowledge of chemistry and physiology, we could achieve far better results in the practice of medicine.

Suggested Reading

Menninger, K.: Changing Concepts of Disease, Ann. Int. Med. **29**:318 (Aug.) 1948.

Menninger, W. C.: Psychiatry and the Practice of Medicine, Bull. Menninger Clin. 17:170 (Sept.) 1953; Cornell University Medical College Alumni Quarterly (July) 1953.

Book Reviews

● Forensic Psychiatry, by Henry A. Davidson, M. D., published by The Ronald Press, New York, 387 pages, $8.00. This book is a guide for physicians on the medico-legal aspects of psychiatry. The physician never knows when he may be called on to testify in court as a witness in the event of legal action involving one of his patients. When such a contingency does arise, the background afforded by Dr. Davidson's comprehensive volume, Forensic Psychiatry, should be of inestimable value to members of the medical profession. The book is divided into two main sections. Part I is concerned with the content of forensic psychiatry, beginning with the fundamental requirements for placing criminal responsibility. Specific legal problems in which the advice of the physician is needed are discussed separately, including such items as personal injury, marriage and divorce, the custody of children, juvenile delinquency, contracts, and appraisal of the sex offender. A separate chapter is devoted to the charge of malpractice as it may affect those dealing with psychiatric patients. Commitment procedures and the civil rights of mentally ill patients are explained in the light of recent legal decisions. Part II of the book is concerned with the tactics of testimony. First, it establishes the difference between a medical fact witness and an expert witness, pointing out how the obligations of the physician may vary with each of these roles.

The legal restrictions as to what constitutes admissable evidence are discussed. Specific examples are taken from court cases which reveal the way in which honest and sincere medical testimony can be distorted and made to sound ludicrous by a lawyer for the opposition. Various methods are cited by which the physician can protect himself from unjust aspersions at the hands of the opposing counsel.

The appendix contains a legal glossary for physicians and a psychiatric glossary for lawyers, which should be extremely useful in producing a common understanding between the two professions. Convenient outlines are provided to assist the physician in making complete examinations in cases which may come to court. Each is slanted so as to embrace all pertinent information in the type of legal action involved. Among these are listed crucial questions which help in the evaluation of the criminal, the personal injury claimant, the drunken driver, the juvenile delinquent, and the mentally incompetent. Frequent citations from medical and legal literature illuminate the pages of this book, emphasizing practical and

specific points, rather than theoretical speculation. It should serve for a long time to come, both as a practical help for physicians and as a common meeting ground for practitioners of medicine and of the law.

● ANNUAL OF PASTORAL PSYCHOLOGY, edited by Simon Doniger, Ph.D. and Rev. Seward Hiltner, was published by the monthly journal, Pastoral Psychology, in Great Neck, New York. Individual copies sell for $1.00, with the selling price scaling downward for purchases in bulk. The ANNUAL lists significant reference material for physicians, psychiatrists, psychologists and ministers—indeed, all workers interested in the field of human behavior. A large section is devoted to a description of significant books on psychiatry, psychology and counseling, as well as mental health films and dramatic presentations. In addition, the ANNUAL contains a listing of psychiatric services, such as resources for clinical training, psychiatric treatment of children and adults, marriage counseling and others. Also included is a glossary of psychiatric terms and an index of material covered in the journal.

● STRESS AND DISEASE, by Harold G. Wolff, M.D., was published by Charles C Thomas, Springfield, Illinois, and sells for $5.50. This significant 180-page monograph contains precise measurements of changes in bodily function associated with emotional stress. Case material is drawn from an extensive body of clinical observation, laboratory experiments and epidemiological surveys.

The thesis of this book differs from the original postulate of psychosomatic medicine in one important respect. In this newer approach, it is not emphasized that stressful emotions *cause* disordered bodily function. Rather, forces which interfere with the fulfillment of man's needs are seen to invoke *both stressful emotions and disordered function.* Both are adaptive response by the individual to threat. These responses may be appropriate or inappropriate in kind, adequate, inadequate or superfluous in amount. A faulty adaptive response to stimuli may be as detrimental to the organism as the original traumatic situation. Indeed, in some cases, it can be *more* destructive. Unsuitable or unduly prolonged adaptive responses may occur throughout the entire body, having been observed in the skin, the gastrointestinal, respiratory, circulatory and metabolic areas. Stress reactions have been produced experimentally with animals in which disordered bodily function was in turn followed by structural damage. In man, similarly damaging responses are frequently encountered. Peptic ulcer, so-called essential hypertension, irritable colon, dermatitis and asthma become more intelligible when viewed from this perspective.

A series of 37 charts graphically illustrates the various bodily changes occurring under experimentally-produced episodes of stress.

● THE BOOK OF HEALTH, edited by R. Lee Clark, Jr., M.D., and Russell W. Cumley, Ph.D., published by Elsevier Press, New York and Houston, $10.00, 836 pages. This is a complete library of medical information for the layman. In no sense a "home treatment" book, this volume instead emphasizes the need to seek competent medical advice at the first signs indicating potential danger.

It is a book which the busy practitioner can advantageously recommend to his patients to supplement the information he has given them. It is devoted to dispelling the antiquated thesis that "what the patient doesn't know won't hurt him." Physicians today know instead that what the patient does not know can kill him. Consequently, the theme which runs through the book alerts the patient to signs which may be ominous though not yet incapacitating. Emphasis is laid on routine prophylactic examinations, all types of preventive medicine, seemingly minor but significant mental disorders, early symptoms of incipient cancer, with the constant reminder to "consult your physician" while there is still time. This is a frank and outspoken volume, and quite a departure from the old-school platitude and placebo type of material formerly prepared for lay consumption. No physician has any cause to fear the position taken in this book except the physician who has not kept abreast of the times and the latest scientific developments. Its widespread acceptance by the lay press indicates that such a book is indeed welcomed by the layman of modern times.

Material covered extends from the beginning of life, through growth and development, into old age. Chapters deal with the various organ systems, their health and disease. Special sections cover disease-producing organisms, sanitation, medical history and the composite team of medical personnel working together for the welfare of the individual patient.

All the major illnesses which beset man are discussed in THE BOOK OF HEALTH. The chapter on The Mind embraces 38 pages and includes pertinent information on the development of the healthy personality, as well as descriptions of the various disorders which threaten or disrupt it. The different neurotic manifestations are presented, together with a simplified illustration of their characteristic behavior patterns and defense mechanisms. Psychosis is discussed in such a manner as to dispel much of the age-old superstition and stigma with which it has been associated in the mind of the layman. Therapies are not dwelt upon, but instead emphasis is laid on the frequently hopeful prognosis when treatment is instituted sufficiently early. The sub-section on mental deficiency is presented with intent to guide the layman to a more tolerant attitude toward individuals with limited mental facilities. Throughout the chapter, the reader is led to a more constructive understanding of those afflicted with impairment of the mind.

Written by 30 professional medical writers and jointly edited by 242 physicians, all authorities in their respective fields of medicine, THE BOOK OF HEALTH contains over 1400 illustrations, many in the form of narrative picture series; a comprehensive index; and an illustrated glossary. It is eventually to be translated into several foreign languages for sale in ten countries.

Dr. Charles W. Mayo has said, "This book can save families many dollars—and perhaps life itself."

Questions and Answers

QUESTION: Do ACTH and Cortisone precipitate psychotic episodes?

ANSWER: In a series of 200 patients receiving massive dosages of ACTH and Cortisone, Glaser reports that eleven (approximately five per cent) developed overt psychotic manifestations. The case histories were carefully examined, together with an exhaustive review of recent literature in the field of steroid therapy.

It has been noted that psychotic reactions are sometimes associated with the *hyperadrenalism* of Cushing's syndrome, and with the *hypoadrenalism* seen in Addison's disease as well. This suggests that maintenance of the hormonal equilibrium is as vital to the psychological processes as it is to physiological ones.

The psychotic reactions which appeared following induced hyperadrenalism were of two kinds. Some patients developed characteristic manic-depressive patterns of behavior with euphoria, irritability and violence alternating with depression, accompanied by an occasional suicidal attempt. These conditions were effectively cleared with the use of electroconvulsive therapy. Other patients revealed a typical organic mental syndrome with memory defect, confusion and delirium, often tinged with paranoid delusions. These states, however, tended to be spontaneously reversible.

In Glaser's patients therapy was instituted for the control of various conditions, prominent among which was rheumatoid arthritis. He reports, "the arthritis symptoms in the patients in this present series remained minimal during the period of the psychotic reaction." This calls to mind the findings of other investigators who have reported that psychotic reactions alternated with active symptoms of rheumatoid arthritis, ulcerative colitis and asthma. Such studies are extremely pertinent in the rapidly accumulating data suggesting that there may exist "a reciprocal or alternating relationship between physical manifestations of psychosomatic illness and active psychotic states."

Reference: Glaser, G. H.: Psychotic Reactions Induced by Corticotropin (ACTH) and Cortisone, Psychosomatic Med. 15:280 (July-Aug.) 1953.

QUESTION: What is the theory behind the Szondi Test?

ANSWER: Countless medical journals and even some lay publications have made vague references to the Szondi Test. Indeed, there are few psychological devices about which so much has been published without some clarification of the thought behind it. It is fairly well known that the test consists of a series of photographs, that these depict various mental patients, and that the person being tested specifies which of the pictures have for him the most (and the least) appeal. On the basis of these selections, certain personality traits and affinities of the viewer are said to be revealed. Usually more space has been devoted to reproducing the photographs than in attempting to explain the reasons underlying their selection.

One reason for this discrepancy may be the acknowledged complexity of Szondi's beliefs. Still another may be found in his emphasis on hereditary mental illness with its somewhat fatalistic prognosis.

In a recent visit to Zurich, Dr. Otto Schwarz called on Dr. L. Szondi, originator of the test. He asked Szondi to clarify the theory underlying his somewhat controversial testing device. The explanation was graciously supplied.

Szondi holds that individuals inherit tendencies to various types of mental illness. If predisposition for the same disease is derived from both parents, the individual is apt to develop overt manifestations of that particular illness. If, however, one inherits this from only one parent, it becomes a recessive trait. Such an individual becomes a "conductor" of that particular type of mental illness. That is to say a normal descendant of mentally ill forbears can carry the pathological hereditary tendency to his children without, himself, falling victim to the disease. This concept is not new with Szondi—it is the premise that he takes up next that isolates him from the geneticist. Szondi goes on to say that those individuals who are genetic conductors of *a specific kind* of mental illness show instinctive but undeniable preferences for one another throughout life. Szondi accounts for choice of love partners, choice of friends and choice of occupation on this basis. He claims that this affinity is discernible in the testing situation. He concludes that those pictures which hold the greatest appeal for

the person being tested will be the photographs of patients whose illness duplicates that found in the viewer's family history.

Thus the implication behind the Szondi theory is that man is instinctively driven and dominated by psychopathological heredity. The validity of this theory is doubted by many psychologists whose field is the projective techniques. And, as Dr. Schwarz observes, "it can easily be seen why Szondi's theories, as they apply to the psychiatric profession, are unlikely to be considered favorably by many of his colleagues."

Reference: Schwarz, O.: Psychiatry in Central Europe, Dis. Nerv. System 14:227 (Aug.) 1953.

QUESTION: Are there any dangers inherent in failure to provide psychotherapy for ulcer patients?

ANSWER: Medical, surgical and psychotherapeutic techniques are all of value in the management of patients suffering from gastric or duodenal ulcer. In severe cases, surgery may be life-saving. However, following gastrectomy, a considerable percentage of ulcer patients develop further psychosomatic or neurotic symptoms, *provided their basic emotional conflicts have not been discovered and mitigated.*

A detailed study was recently undertaken by Browning and Houseworth in an effort to determine how frequently the removal of symptoms in a psychosomatic disease is followed by the formation of new and different symptoms. Two groups of 30 ulcer patients each were selected for comparison. The first group was comprised of patients treated by gastrectomy. The second group—the controls—consisted of patients who were treated only by conservative medical means. Neither group was given any psychotherapy.

As anticipated, the surgically-treated group of patients showed a significant decrease in *ulcer* symptoms. However, other symptoms appeared. Of these, psychosomatic symptoms (other than gastrointestinal) increased by 24 per cent, and psychological disturbances rose 50 per cent. In contrast, the medically-treated group retained most of their ulcer symptoms, but *failed to develop any* new symptoms of a different type. Both groups were followed for twelve to eighteen months, with each patient receiving thorough psychiatric investigation, as well as medical, laboratory and x-ray examination.

Among the manifestations frequently recognized as functional which appeared among the post-surgical patients were hypertension, migraine, dermatitis, diarrhea and musculo-skeletal stiffness and pain. The psychological symptoms they developed included severe anxiety and depression, phobias, obsessions and compulsions. The control group, unrelieved of ulcer pain, failed to show a comparable redistribution of symptoms. The investigators felt that this study largely confirmed the thesis that ulcer is a faulty adaptive response of the organism, in which removal of the symptoms without resolution of the associated conflicts is likely to be followed by the appearance of further symptoms.

Reference: Browning, J. S. and Houseworth, J. H.: Development of New Symptoms Following Medical & Surgical Treatment for Duodenal Ulcer, Psychosomatic Med. 15:328 (July-Aug.) 1953.

AMBULATORY SCHIZOPHRENIA

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It should be used with great caution, as an acute psychotic reaction may be precipitated when the patient becomes aware of painful feelings which formerly had been repressed.

Course of the Disease

The course of this disease is like that of most others. Recovery may occur under favorable circumstances. It may remain static, or there may be periodic exacerbations. It may progress to the classical picture of schizophrenia with delusions, hallucinations and deterioration. A number of these patients have psychotic episodes which are usually short in duration and followed by complete reintegration of the personality. This accounts for the fact that the same patient may be diagnosed as neurotic by one physician at one time, and as schizophrenic by another physician at a different time. Often their day dreams gradually intensify to hallucinations. Their vague hypochondriacal ideas become somatic delusions. Anxiety-laden ideas of their relations with others may gradually merge into ideas of reference. Ideas and perceptions are at first merely overvalued. They may say at first, "It is as though I heard a voice." When the emotion intensifies it becomes, "I hear a voice." These people dip in and out of reality for short periods, which might be thought of as micropsychoses. In the shortlived psychotic episodes, three significant elements are present—hypochondriacal ideas, ideas of special reference to themselves and feelings of depersonalization.

Treatment

Some psychiatrists feel psychoanalysis is the treatment of choice, but many prefer insulin shock and

psychotherapy. In dealing with these patients it is not advisable to bring out unconscious material against which they are defending themselves unless hospitalization is available, since it may throw them into a frank psychosis. Some may be treated in an office or a day hospital, although others may require a closed psychiatric hospital. The setting in which treatment occurs depends on how well the ego is dealing with reality. A closed hospital is certainly recommended for patients who have strong homicidal or suicidal trends, or whose behavior is conspicuously abnormal or uncontrollable. An open hospital, when available, is best for the patient who is not too sick since this helps preserve the sense of self-esteem and responsibility and he maintains a feeling of inner control over himself. These functions are particularly important to the borderline schizophrenic who constantly feels in danger of losing them.

Prognosis

Regardless of the type of therapy used, the therapist-patient relationship is of major significance in the ultimate prognosis. In many instances, a good adjustment retaining schizoid elements of the personality is the therapeutic goal, rather than "normality." These people are not hopeless. Too few of them have been adequately studied and adequately treated for hard and fast statements to be made concerning them. Although the criminal and murderous type of person is found among them, the majority are not criminals. Mostly they are quiet, unobtrusive, ineffective people who seem to be chronic failures. Whether they remain in this state, progress to a devastating psychosis, or come to treatment with the hope that it offers, frequently depends in a large measure on the physician who first sees them.

Suggested Reading

Hoke, P. and Toltain, T.: Pseudo-Neurotic Forms of Schizophrenia, Psychiatric Quart. 23:249 (Jan.) 1949.

Kasanin, J. S.: Language and Thought in Schizophrenia, Berkeley and Los Angeles, U. of Calif. Press, 1946, p. 41.

Knight, R. T.: Management and Psychotherapy of Borderline Schizophrenic Patients, Bull. Menninger Clin. 17:139 (July) 1953.

Lipton, S. D.: Some Comparisons of Psychotherapeutic Methods in Schizophrenia, Psychiatric Quart. 23:704 (Oct.-Dec.) 1949.

Reichardt, S. and Tillman, C.: Murder and Suicide as Defenses Against Schizophrenic Psychosis, J. Clin. Psychopath. 11:149 (Oct.) 1950.

Zilboorg, G.: Ambulatory Schizophrenias, Psychiatry 4:149 (May) 1951.

RUSH

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mental illness stemmed from lesions in the brain. Specifically, he thought that hypertension in the cranial arteries was involved; thus bleeding was considered beneficial for mental patients. Indeed, those who were extremely violent often became calmer following this treatment, no doubt as a result of their weakened condition. At this time, all medical therapies were heavily influenced by the teachings of Galen. Thus, venesection, leeching, purging and the administration of violent emetics were in wide usage for all types of illness. In addition to these measures, Rush employed the prevailing methods for startling patients, such as dunking, unexpected showers, and spinning them around in a mechanical "gyrator." These practices appear primitive when viewed by modern standards, yet they were administered with sincere concern for the patients, and were reported to have had a soothing effect.

Rush insisted that patients should be effectively dominated by their physicians, even intimidated if they became refractory, yet he condemned unkind punitive practices, such as whipping or confining them to uncomfortable quarters. Entirely new in the handling of mental patients was his suggestion that they record their impressions of matters troubling them. This may have been recommended more in kindness than with therapeutic intent. At any rate, he eventually stated that emotional disturbance and mental distress could be equally as conducive to insanity as could somatic factors. This was in an age when psychological forces were deemed scarcely worth mentioning in the etiology of mental disorder.

Rush is credited with yet another innovation. As the first advocate of occupational therapy, he wrote, "Certain employments should be devised for such of the deranged people as are capable of working." With the insane not two decades removed from dungeons and whipping posts, this type of management was indeed in advance of the times.

Following the death of Rush in 1813, more than 50 years elapsed before psychiatric teaching was added to the medical curricula in the United States. Yet, during that half-century, the precepts of his text guided physicians in administering to patients with disorders of the mind.

Suggested Reading

Bunker, H. A.: American Psychiatry as a Specialty, in One Hundred Years of American Psychiatry, New York, Columbia University Press, 3rd ed, 1947, p. 479.

Hamilton, S. W.: The History of American Mental Hospitals, in One Hundred Years of American Psychiatry, New York, Columbia University Press, 3rd ed, 1947, p. 73.

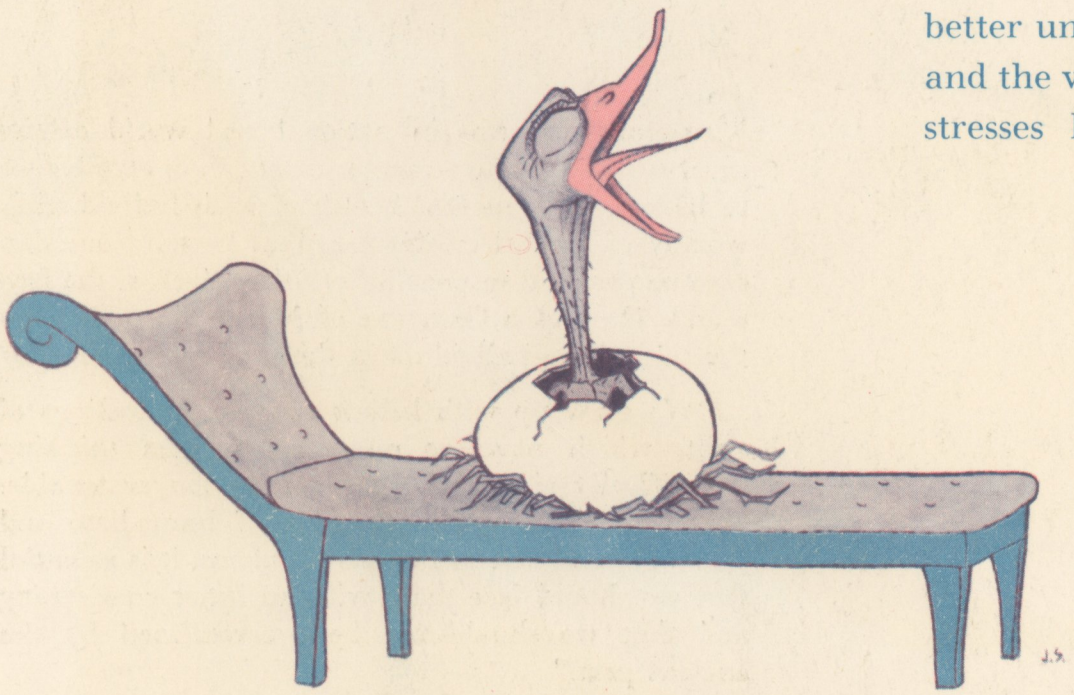
Malamud, W.: The History of Psychiatric Therapies, in One Hundred Years of American Psychiatry, New York, Columbia University Press, 3rd ed, 1947, p. 273.

Zilboorg, G. and Henry, G. W.: A History of Medical Psychology, New York, W. W. Norton & Co., 1941, pp. 262, 299, 410.

PSYCHIATRY *and citizenship*

CHANGING TRENDS in national and world affairs involve all people to a greater extent than ever before in history. The mental health of each individual is worthy of careful cultivation, that he may one day assume personal responsibility as a citizen of the free world. Dr. Ewen Cameron of Montreal emphasizes the role of the individual in the progress of nations:

"We grew up with beliefs concerning feelings of guilt, which now, as men and women thinking scientifically about behavior, are no longer tenable. When faced with the pressures of immediate and personal involvement in such problems, it is essential that we should face them with an inner consistency and that we should not be overwhelmed by the ancient past."



"To the field of physical health where so much has been done toward prevention of formerly common childhood diseases, slowly but surely are being added gains in the mental health field; detection and prevention of the mental disorders of children, better understanding of the cycles of growth and the vital periods of development at which stresses hold peculiar emotional hazards."

Mental Health—Everybody's Business
Public Health Pamphlet No. 196.